TRIDENT ADVENTURES

U.S. NAVY SEAL OWNED AND OPERATED

Required For Helicopter Cast Master Course Enrollment

- ☐ Start the enrollment process at least 30 days prior to start of course in order to successfully apply for VA benefits.

- ☐ Complete the Trident Course Registration Form, the PADI Professional Program Enrollment Agreement, and the Diver Medical Questionnaire (which must be signed by a Physician or Physician Assistant regardless if all boxes are checked "NO").

- ☐ $97.50 registration fee is due PRIOR to attendance to secure class of choice. A representative from Trident Adventures will contact you to obtain payment upon submission of the Enrollment Agreement. Please retain receipt.

- ☐ Provide copy of DD-214 and Certificate of Eligibility

- ☐ Provide any unofficial transcripts and military transcripts

- ☐ Provide copies of PADI and non-Padi dive certifications

All documents can be submitted electronically to the School Certifying Official, Cindy Hutchinson at enroll@tridentadventures.com, or turned in to a representative at Trident Adventures, or via US Mail to: Trident Adventures, 3 Aloha Tower Dr, Unit 1123, Honolulu, HI 96813.

www.tridentadventures.com
3 Aloha Tower Dr., Suite 1123, Honolulu, HI 96813
Phone: (808) 762-3483 / email: enroll@tridentadventures.com

Professional Course Registration Form

Please complete the information below. Sign, date and deliver to Trident Adventures with your $97.50 payment check (at the address above) along with any previous certification documentation. Each participant must fill out this form separately. Forms will not be processed without your signature.

Requested Program (Specify Title): _____
Prior Dive Certifications: _____
Prior Helicopter Cast (or equivalent) Qualifications/Certifications: _____
Name: _____ DOB: _____ (dd/mm/yyyy)
SSN: _____ Veteran (Active or Ret): _____
Phone: _____
Mailing Address: _____
Email Address: _____
Emergency Contact Name: _____ Phone: _____

The $97.50 registration fee is not refundable for any reason. However, should you notify us regarding cancellation prior to 14 days before the start date of the course, we will apply your deposit towards a future course of your choice. Many courses fill up several days before they start, mailing your payment check does not guarantee a space. In the event the course reaches the full capacity before your payment is received, your check will be returned by mail at the address provided above.

I have carefully read the statement above and by signing below I agree to the aforementioned terms.

Signature: _____ Date: _____ (dd/mm/yyyy)
Do not Digitally Sign these Documents until ALL FIELDS are filled in. Once signed, the document will no longer allow changes.

TRIDENT ADVENTURES

Helicopter Cast Master Professional Program Enrollment Agreement

Welcome to your Helicopter Cast Master (CM) Course of Instruction (COI). As a CM professional, you will gain valuable experience in the industry. This program is designed to enhance your skills and provide you with new tools to use as a CM professional. During this program, you'll receive a full orientation to the CM education. By signing this Enrollment Agreement, you indicate that you are aware of and accept this responsibility as outlined below by this agreement.

As a Trident Adventures Professional Cast Master Candidate, you agree to the following:

1. **Complete and turn into the School Certifying Official (pg. 6) before the first class session:**
   a. Completed the Helicopter Cast Master Medical Participant Questionnaire (Appendix A-17), signed by an *authorized Medical Professional, ie. M.D. or Physician's Assistant,* as required by Trident Adventures' standards for any professional level program. The Cast Master Medical Participant Questionnaire must be within twelve months of the course enrollment with all dates (including Medical Professionals) in proper date format (dd-mm-yyyy) and remaining valid for all dates of anticipated attendance. RN, Nurse Practitioner or LPN signatures not accepted. No exceptions.
   b. Copies of PADI or non-PADI dive certifications, to include Open Water, Rescue, and/or EFR (or equivalent) level certifications documentation, if applicable for prior credit evaluation. If I am utilizing VA Benefits, I understand the VA does not authorize payment for certifications previously completed.
   c. Copies of all college transcripts, unofficial transcripts are accepted.
   d. Copies of any military, governmental, or civilian certifications or qualifications pertinent in the field of the Cast Master program (i.e. HRST/Cast Master, Aircrew, Static-Line Jump Master, Military Freefall Jump Master, etc.). If I am utilizing VA Benefits, I understand the VA does not authorize payment for certifications previously completed.
   e. For students utilizing VA Benefits only: DD214, Certificate of Eligibility, DD22-1995 Change of Program form.

2. **Tuition and fees notice for Veterans utilizing VA benefits:**
   a. I have reviewed and agree to pay the tuition/fees schedule as outlined in the catalog. If for any reason the VA benefits will not cover the program in full or in part, I agree to pay the remaining balance to Trident Adventures.
   b. I understand that full time pursuit for VA Beneficiaries is at least 22 hours per week.
   c. I understand if I withdraw from the program for <u>any reason</u>, the VA treats the withdrawal as a termination, which may trigger a debt from the Debt Management Center. However, if I return to complete the program within a 12-month period from the last date of attendance, a credit will be applied for used tuition, books, eLearning and activity fees. If I withdraw for medical reasons, upon return a new Helicopter Cast Master Participant Medical Questionnaire and all associated medical forms must be completed to re-enroll.

d. I understand that all issued TA equipment/gear is my responsibility to return to TA upon completion of a course, or termination during a course. It is my responsibility to pay for any damaged, excessive wear and tear, or missing equipment/gear that was issued to me.

3. **Tuition and fees Notice for Non-Veteran Students:**
   a. I have reviewed the tuition and fees schedule as outlined in the catalog. Payment in full is due prior to the first day of training.
   b. I understand that all equipment/gear must be returned to TA upon completion of a course or termination from a course.
   c. I understand that all financial obligations must be paid before a certificate will be issued.

4. **Knowledge Review Requirement before First Day of Class**
   a. I agree to complete all knowledge reviews, assigned homework, and will be prepared to discuss, grade and stay late for academic remediation, if required.
   b. If I arrive at class without completed assignments, or fail to arrive on time, it may be necessary to make up the work and continue the program at a later date.

   NOTE: *You will be responsible for any additional costs including additional required resources and instructors. In scheduling and determining additional make-up sessions and cost (pg. 11), your Course Director and/or Training Manager agrees to give every reasonable consideration to unforeseen events such as immediate family emergencies that lead to this situation.*

5. **Follow all program procedures as set forth by the Course Director and Training Manager.**

6. **Ask questions about anything not understood.**

7. **Show up for all sessions on time or early; be prepared for all teaching assignments and have the necessary assignments completed.**

8. **Be open minded and display a professional attitude, appearance, and demeanor during the program.**

9. **Be flexible to schedule changes. Unforeseen circumstances which may require rescheduling class: inclement weather such as high surf warnings.**

10. **The Course Director, Training Manager and Staff agree to:**
    a. Treat you with respect.
    a. Start the class as scheduled.
    b. Provide a positive learning environment in which to master the program objectives.
    c. Answer your questions to the best of their ability.
    d. Assist you through learning challenges.

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10. I acknowledge that I am at least 18 years of age.

11. This agreement is legally binding. The policies found in this agreement as well as in the catalog constitute a whole agreement between all parties. By signing this agreement, I do recognize I am entering into a legally binding contract with Trident Adventures.

Name (print): _____ Email: _____

Date of Birth: _____ Phone: _____

Address:

_____

_____

Active Duty (Yes or No): _____ Chapter 30 or 33: _____

Years of Service: _____ Payment Method: _____

Candidate Signature: _____ Date: _____

Training Manager Name: _____

Training Manager Signature: _____ Date: _____

Helicopter Cast Master | Participant Questionnaire

Helicopter Cast Master roles and responsibilities requires good physical and mental health. There are a few medical conditions which can be hazardous while functioning as a Cast Master (CM). Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your physical fitness not represented on this form, consult with your physician before enrolling in the Caster Master Course of Instruction. If you are feeling ill, avoid all roles as a CM. If you think you may have a contagious disease, protect yourself and others by not participating in any training and/or activities. This form is principally designed as an initial medical screen for new CM's, but is also appropriate for CM's looking to continue their education in a diving profession. For your safety, and that of others whose safety you will be directly in charge of, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.

Note to women: If you are pregnant, or attempting to become pregnant, *do not dive.*

1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.	Yes ☐ *Go to Box A*	No ☑
2. I am over 45 years of age.	Yes ☐ *Go to Box B*	No ☐
3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes ☐*	No ☐
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes ☐ *Go to Box C*	No ☐
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes ☐*	No ☐
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes ☐ *Go to Box D*	No ☐
7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability.	Yes ☐ *Go to Box E*	No ☐
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ *Go to Box F*	No ☐
9. I have had stomach or intestine problems, including recent diarrhea.	Yes ☐ *Go to Box G*	No ☐
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes ☐*	No ☐

Participant Signature

If you answered *NO* to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

Participant Statement: I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

_____ _____

Participant Signature (or, if a minor, participant's parent/guardian signature required.) | Date (dd/mm/yyyy)

_____ _____

Participant Name (Print) | Birthdate (dd/mm/yyyy)

_____ TRIDENT ADVENTURES

Instructor Name (Print) | Facility Name (Print)

*** If you answered *YES*** to questions 3, 5 or 10 above ***OR*** to any of the questions on page 2, please read and agree to the statement above by signing and dating it ***AND* take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

Participant Name _____ **Birthdate** _____

(Print) Date (dd/mm/yyyy)

Helicopter Cast Master | Participant Questionnaire Continued

Box A – I have/have had:		
Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	Yes ☐*	No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐*	No ☐
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes ☐*	No ☐
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes ☐*	No ☐
A diagnosis of COVID-19.	Yes ☐*	No ☐

Box B – I am over 45 years of age AND:		
I currently smoke or inhale nicotine by other means.	Yes ☐*	No ☐
I have a high cholesterol level.	Yes ☐*	No ☐
I have high blood pressure.	Yes ☐*	No ☐
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes ☐*	No ☐

Box C – I have/have had:		
Sinus surgery within the last 6 months.	Yes ☐*	No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐*	No ☐
Recurrent sinusitis within the past 12 months.	Yes ☐*	No ☐
Eye surgery within the past 3 months.	Yes ☐*	No ☐

Box D – I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes ☐*	No ☐
Persistent neurologic injury or disease.	Yes ☐*	No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐*	No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes ☐*	No ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

Box E – I have/have had:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐*	No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐*	No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes ☐*	No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐*	No ☐

Box F – I have/have had:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐*	No ☐
Back or spinal surgery within the last 12 months.	Yes ☐*	No ☐
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes ☐*	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐*	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐*	No ☐

Box G – I have had:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐*	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐*	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes ☐*	No ☐
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes ☐*	No ☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes ☐*	No ☐
Bariatric surgery within the last 12 months.	Yes ☐*	No ☐

*Physician's medical evaluation required (see page 1).

Helicopter Cast Master | Physician's Evaluation Form

Participant Name _____ Birthdate _____
(Print) Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

_____ _____
Physican's Signature Date (dd/mm/yyyy)

Physician's Name _____ Specialty _____
(Print)

Clinic/Hospital _____

Address

Phone _____ Email _____

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego